STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155139	A. BUILDING B. WING		03/01/2012
				ADDRESS, CITY, STATE, ZIP CODE	L
NAME OF I	PROVIDER OR SUPPLIE	R		/ JEFFERSON ST	
NORTH V	WOODS VILLAGE			MO, IN 46901	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	•	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F0000					
1 0000					
	This visit was fo	or the investigation of	F0000		
		or the investigation of	10000		
	Complaints IN0	0104295 and			
	IN00104351.				
	_	1104295 - Substantiated,			
	Federal deficien	icies related to the			
	allegation are ci	ted at F-223, F-225. and			
	F-226.	•			
	Complaint INOC	0104351 - Substantiated,			
	_				
		icy related to the			
	allegation are ci	ted at F-282 and F-323.			
	Survey dates: F	February 29 and March 1,			
	2012				
	Facility number	: 000064			
	Provider numbe				
	AIM number: 1				
	7 HIVI Halliott. 1	100200770			
	Survey teem:				
	Survey team:	L DNI TC			
	DeAnn Mankell				
	Shelley Reed, R	LN			
	Census bed type	2:			
	SNF: 16				
	SNF/NF: 136				
	Total: 152				
	Census payor ty	me.			
	Medicare: 31	pc.			
	Medicaid: 92				
LABORATOR	Y DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S SI	IGNATURE	TITLE	(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 03/26/2012 FORM APPROVED OMB NO. 0938-0391

	DF CORRECTION IDENTIFICATION NUMBER: 155139	(X2) MULTIPLE CON A. BUILDING B. WING	00	COMPLETED 03/01/2012
	ROVIDER OR SUPPLIER WOODS VILLAGE	2233 W 3	DDRESS, CITY, STATE, ZIP CODE JEFFERSON ST O, IN 46901	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	Other: 29 Total: 152			
	Sample: 5 Supplemental Sample: 5			
	These deficiencies also reflect state finding cited in accordance with 410 IAC 16.2.			
	Quality review completed 3/6/12 Cathy Emswiller RN			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LPKM11

Facility ID: 000064

If continuation sheet

Page 2 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155139 NAME OF PROVIDER OR SUPPLIER			LDING G	ONSTRUCTION 00 ADDRESS, CITY, STATE, ZIP CODE	(X3) DATE COMPL 03/01/	ETED	
	WOODS VILLAGE				/ JEFFERSON ST MO, IN 46901		
					WO, IN 46901		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
F0223 SS=D	SECLUSION The resident has verbal, sexual, ple corporal punishm seclusion. The facility must sexual, or physic punishment, or in Based on interviet the facility failed from verbal abus sample of 5 reviet (Resident D) Findings include 1. During an inteam, Resident D into her room aft on for awhile. Trindicated the call and proceeded to sure it was working resident indicated stood over her and there" while point The resident said staff member beforeported the incident the ADON.	the right to be free from hysical, and mental abuse, nent, and involuntary not use verbal, mental, all abuse, corporal hyoluntary seclusion. Ew and record review, to ensure a resident was a for 1 of 5 residents in a swed for abuse. Erview on 2/29/12 at 9:50 indicated someone came er she had her call light	F02	23	The creation and submission this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credit Allegation and requests a Des Review in lieu of a post surverevisit on or after March 26, 2012. F 223 Free From Abuse/Involuring Abuse/Involuring Seclusion It is the practice of this provide on the practice of this provide on the practice of this provide on the practice of the provided on the practice of the practice	ot st t n of sible sk y	03/26/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LPKM11

Facility ID: 000064

If continuation sheet

Page 3 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DUILDING	00	COMPLETED
		155139	A. BUILDING B. WING		03/01/2012
			_	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIE	R		W JEFFERSON ST	
NORTH WOODS VILLAGE			MO, IN 46901		
				10001	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
TAG		R LSC IDENTIFYING INFORMATION)	TAG		DATE
		um data set (MDS)		sexual, physical, and mental abuse, corporal punishment a	and
		d 2/3/12, indicated the		involuntary seclusion. Wha	l l
	resident had a bi	rief interview mental		corrective action(s) will be	•
	status (BIMS) so	core 14 of 15. This BIMS		accomplished for those	
	score on the MD	OS indicated the resident		residents found to have bee	n
	was reliable and	interviewable.		affected by the deficient	
				practice · Resident D	
	Resident D's dia	gnoses included, but not		interviewed and Social Servi	
	limited to, multi	_		assessment were performed	
		•		no negative outcome. · LPI	N #2
	encephalopathy,	and depression.		interviewed along with 2 witnesses, incident was	
				unsubstantiated LPN #2 give	n l
	During an interv	riew on 2/29/12 at 10:45		compassionate caregiver on	
	a.m., the ADON	indicated she was called		2-21-12 by the Assistant Dire	ctor
	into Resident D'	s room on 2/20/12 at 1:00		of Nursing (ADNS) . How	will
	p.m. The reside	nt indicated her call light		you identify other residents	
	was on for more	than one hour at 1:00		having the potential to be	
	a m on 2/20/12	before being answered.		affected by the same deficie	
		d a nurse had entered her		practice and what corrective	
		ked for ice. The resident		action will be taken Residents in the facility have	the
		rse left and did not come		potential to be affected by the	l l
				alleged deficient practice.	
	-	ed the call light on again.		Other Residents in the facility	
		ed her room again and		were interviewed and no	
	1	ling at the nurse. The		concerns were voiced · Nurs	sing
	resident indicate	ed the nurse leaned in		staff will be re-educated on	and
	close to her face	and dared the resident to		alleged abuse, investigations reporting appropriately includ	l l
	hit her. The resi	dent stated to the ADON		notifiying Executive Director	· .
	she was unsure	of who the nurse was but		immediately of any allegation	
	gave a description	on of the staff member in		abuse, neglect or	
	her room.			misappropriation of property b	
				3-23-12 by the SDC/designed	e. If
	During an intern	view on 2/20/12 of 11:15		ED is not notified appropriate	un un
	_	riew on 2/29/12 at 11:15		disciplinary action will be take to and including	iii up
	·	vice #3 indicated she met		termination. What	
		t following the allegation		measures will be put into pla	ace
	of verbal abuse	on 2/20/12 at 10:53 a.m.			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LPKM11

Facility ID: 000064

If continuation sheet

Page 4 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULT		ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ETED	
		155139				03/01/	2012
			B. WIN		ADDRESS OFTW STATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP CODE		
					JEFFERSON ST		
NORTH WOODS VILLAGE			KOKON	ЛО, IN 46901			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Resident D resta	ted the incident to social			or what systemic changes yo	ou	
	service. The res	ident stated she was			will make to ensure that the		
		g about her daily routine.			deficient practice does not		
	_	-			recur · Staff will be		
		3 indicated the resident			re-educated by 3-23-12 by the		
	did not have a hi				SDC/designee on Abuse polic		
	allegations and s	he was surprised by the			being followed, proper reportir	ng	
	verbal abuse alle	gation.			and investigations of alleged		
					abuse. · Investigation was		
	During review o	f the investigation report			completed and the nurse #2 v given compassionate caregive		
	_	on 2/29/12 at 10:45 a.m.,			training on 2-21-12 by Assista		
	_	•			Director of Nursing (ADNS)		
	_	ted on 2/20/12 at 1:00			Staff was educated on proper		
	p.m., Resident D	reported to the Assistant			reporting alleged abuse and		
	Director of Nurs	ing (ADON) at 1:00 a.m.,			investigation 3-6-12 and by		
	on 2/20/12 that I	LPN #2 came into her			3-23-12 by SDC/Designee.		
	room after reside	ent placed call light on			Staff report allegations of abus	se,	
		to resident's face and			to their immediate supervisor.		
					The Executive Director and/or		
	_	t there" and pointed to			Director of Nursing Services is		
	LPN #1's chin.				notified and initiate the report the appropriate regulatory	lO	
					agencies. Including notifiying I	=D	
	The ADON's inv	restigation indicated she			immediately of any allegation		
	had interviewed	5 residents, identified as			abuse, neglect or	.	
		H, I, and J, who reside in			misappropriation of propery. I	f	
		here the incident took			ED is not notified appropriate		
					disciplinary action will be taker	n up	
		safety and abuse. During			to and including termination.		
		e ADON indicated that			Residents who have an allege	d	
	LPN #2 who was	s identified as the staff			abuse will have a complete		
	member involve	d in the incident did not			investigation initiated and		
	work in the area	of the incident and she			residents throughout the facilit		
		rviewed residents who			will be interviewed to determin abuse has occurred and if	le II	
		where LPN #2 worked.			residents feel safe. • This		
	reside ili die alea	i where Li in #2 worked.			investigation will include		
					interviews of staff, other		
	,	2012 at 9:00 a.m., the			residents, and family members	s if	
	Administrator pr	ovided a policy entitled,			necessary. Physician and		
	"Abuse Prohibiti	on, Reporting, and			family will be notified of		

PRINTED: 03/26/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155139	B. WING		03/01/2012
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIE	R		W JEFFERSON ST	
NODTU	WOODS VILLAGE			MO, IN 46901	
NORTH	WOODS VILLAGE		KOKC	NO, IN 4090 I	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	Infestation," wit	h a review date of		allegations of abuse as neede	d.
	*	This policy indicated, "		· Employees that are implicat	ed
	_	• •		in an allegation of abuse are	
	_	gation will include: Facts		removed from the schedule, to	
	and observations	s from others who might		ensure resident safety, until th	
	have pertinent in	nformation"		investigation is completed.	
				interdisciplinary team will revie	ew
	This Federal tag	relates to complaint		the "24 Hour Report" and	
	#IN00104295	relates to complaint		"Change of Condition" forms forms	
	#11100104293			physician and family notification	on
				Monday – Friday (excluding	
	3.1-27(b)			holidays) at clinical meeting.	
				Employees will have a crimina	11
				history check upon hire.	
				Employees will receive abuse prevention training upon hire a	and
				at least annually thereafter.	anu
				The nursing manager on call i	
				notified of acute resident chan	
				on the weekend. DNS/ED is	900
				notified as needed. • The	
				Executive Director/Designee is	s
				responsible for compliance with	I
				the Abuse Policy and Procedu	
				and the reporting of allegation	
				abuse. How the corrective	
				action(s) will be monitored to	
				ensure the deficient practice	
				will not recur, i.e., what quali	ty
				assurance program will be p	ut
				into place · The CQI tool	
				"Staff Treatment of Residents"	,
				will be utilized by the	
				Interdisciplinary Team weekly	for
				four weeks, monthly for three	
				months, and quarterly until	
				compliance is achieved for two	
				consecutive quarters. · The	
				DNS or designee is responsib	
				to monitor for compliance.	Γhe
				CQI team reviews the audits	
				monthly and action plans are	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LPKM11

Facility ID: 000064

If continuation sheet

Page 6 of 26

PRINTED: 03/26/2012 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155139	A. BUILDING B. WING	00	COMPLETED 03/01/2012
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE / JEFFERSON ST	
NORTH V	WOODS VILLAGE			MO, IN 46901	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	developed if threshold of 100% not achieved to ensure contin compliance. Compliance date: March 26, 2012	6 is
			I .	İ.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LPKM11

Facility ID: 000064

If continuation sheet Page 7 of 26

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTII	PLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	0	00	COMPL	ETED
		155139	B. WING	J		03/01/	2012
				DEET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	L.					
NODTU	4/00D0 \ /!! 4.0E				JEFFERSON ST		
NORTH	WOODS VILLAGE		I KC	JKUW	O, IN 46901		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREF	FIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TA	.G	DEFICIENCY)		DATE
F0225	483.13(c)(1)(ii)-(iii), (c)(2) - (4)					
SS=D	INVESTIGATE/F						
	ALLEGATIONS/	INDIVIDUALS					
	The facility must	not employ individuals who					
		I guilty of abusing,					
	neglecting, or mi	streating residents by a court					
	of law; or have h	ad a finding entered into the					
	State nurse aide	registry concerning abuse,					
	neglect, mistreat	ment of residents or					
		of their property; and report					
		t has of actions by a court of					
	_	mployee, which would					
		s for service as a nurse aide					
		taff to the State nurse aide					
	registry or licens	ing authorities.					
	The facility must	ensure that all alleged					
	_	ng mistreatment, neglect, or					
		injuries of unknown source					
		ation of resident property are					
		ately to the administrator of					
		o other officials in accordance					
	•	rough established					
		uding to the State survey and					
	certification ager						
		have evidence that all					
	_	s are thoroughly investigated,					
		nt further potential abuse					
	while the investig	gation is in progress.					
	The results of all	investigations must be					
		dministrator or his					
		esentative and to other					
		dance with State law					
		State survey and certification					
		working days of the incident,					
		d violation is verified					
	•	ective action must be taken.					
		ew and record review,	F0225	j			03/26/2012
					E 005		-
	the facility failed	i to morouginy			F 225		
			1				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LPKM11

Facility ID: 000064

If continuation sheet

Page 8 of 26

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155139		LDING	00	(X3) DATE S COMPLE 03/01/2	ETED	
	ROVIDER OR SUPPLIER		2233 W	ADDRESS, CITY, STATE, ZIP CODE JEFFERSON ST MO, IN 46901	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
		llegation of abuse for 1 of ample of 5 reviewed for t D)		Investigate/Re	p	
	Findings include	:		allegation/indi	v	
	of alleged abuse a.m., the investiga 2/20/12 at 1:00 pto the Assistant I (ADON) at 1:00 LPN #2 came intresident placed c close to resident' right there," and During interview a.m., the ADON interviewed 5 residenty and abuse the ADON indicates a fety and abuse the ADON indicates involved in the inthe area of the inhave interviewed the area where L. This Federal tag #IN00104295	sidents, Resident's F, G, reside in the same hall nt took place, regarding. During the interview, ated that LPN #2 who the staff member neident did not work in cident and she should I residents who reside in		It is the practice of this proviot to ensure alleged violations involving mistreatment, neglector abuse are reported immediately to administration the facility and appropriate investigation and corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Resided D interviewed and Social Servassessment were performed whom negative outcome. LPN interviewed along with 2 witnesses, incident was unsubstantiated LPN #2 given compassionate caregiver on 2-21-12 by ADNS. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. Residents in the facility have the potential to be affected by the alleged deficient practice. Other Residents in the facility were interviewed and no concerns were voiced. Nursestaff will be re-educated on alleged abuse, investigations as	et, of etion ed ent vice vith I #2 II ht	
	_	•		concerns were voiced · Nurs staff will be re-educated on		

PRINTED: 03/26/2012 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155139	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/01/2012
	ROVIDER OR SUPPLIER		2233 W	ADDRESS, CITY, STATE, ZIP CODE / JEFFERSON ST MO, IN 46901	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
				reporting appropriately includinotifying ED immediately of a allegation of abuse, neglect or misappropriation of property by 3-23-12 by the SDC/designed ED is not notified appropriated disciplinary action will be take to and including termination. What measures will be put into play or what systemic changes youll make to ensure that the deficient practice does not recur. Staff will be re-educated by 3-23-12 by the SDC/designee on Abuse policibeing followed, proper reporting and investigations of alleged abuse. Investigation was completed and the nurse #2 given compassionate caregive training on 2-21-12 by Assista Director of Nursing (ADNS). Staff was educated on proper reporting alleged abuse and investigation 3-6-12 and by 3-23-12 by SDC/Designee. Staff report allegations of abuse to their immediate supervisor. The Executive Director and/or Director of Nursing Services in notified and initiate the report the appropriate regulatory agencies. Including notifying immediately of any allegation abuse, neglect, or misappropriation of property. ED is not notified appropriate disciplinary action will be take to and including termination. Residents who have an allege abuse will have a complete	ny r py e. If ly, en up ace ou ecy ng was er ant . se, r s to ED of If en up .

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LPKM11

Facility ID: 000064

If continuation sheet

Page 10 of 26

PRINTED: 03/26/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155139	(X2) MULTIPLE CO	00	COMPLETED 03/01/2012
		100108	B. WING	ADDREGG GIVEN COLUMN	03/01/2012
	PROVIDER OR SUPPLIED	R	2233 W	ADDRESS, CITY, STATE, ZIP CODE / JEFFERSON ST MO, IN 46901	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				investigation initiated and residents throughout the facili will be interviewed to determine abuse has occurred and if residents feel safe. This investigation will include interviews of staff, other residents, and family member necessary. Physician and family will be notified of allegations of abuse as needed. Employees that are implicated in an allegation of abuse are removed from the schedule, to ensure resident safety, until the investigation is completed. Interdisciplinary team will reviet the "24 Hour Report" and "Change of Condition" forms of physician and family notification. Monday – Friday (excluding holidays) at clinical meeting. Employees will have a criminal history check upon hire. Employees will receive abuse prevention training upon hire at least annually thereafter. The nursing manager on call in notified of acute resident char on the weekend. DNS/ED is notified as needed. The Executive Director/Designee is responsible for compliance with the Abuse Policy and Proceduland the reporting of allegation abuse. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what qual assurance program will be printo place. The CQI tool "Staff Treatment of Residents"	ne if ed. ted one The tew for on . al and dis and di

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LPKM11

Facility ID: 000064

If continuation sheet

Page 11 of 26

PRINTED: 03/26/2012 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CC	00	COMPLETED
		155139	B. WING		03/01/2012
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE / JEFFERSON ST	
NORTH V	WOODS VILLAGE			MO, IN 46901	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	will be utilized by the Interdisciplinary Team weekly four weeks, monthly for three months, and quarterly until compliance is achieved for two consecutive quarters. The DNS or designee is responsi to monitor for compliance. CQI team reviews the audits monthly and action plans are developed if a threshold of 10 is not achieved to ensure continual compliance. Compliance date: March 26 2012	y for yo ble The
				1	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LPKM11

Facility ID: 000064

If continuation sheet

Page 12 of 26

PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	STATEMENT	Γ OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
NAME OF PROVIDER OR SUPPLIER NORTH WOODS VILLAGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F0226 483.13(c) SS=D DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of	AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A BIII	DING	00	COMPL	ETED
NAME OF PROVIDER OR SUPPLIER NORTH WOODS VILLAGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F0226 483.13(c) SS=D DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of			155139				03/01/	2012
NORTH WOODS VILLAGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F0226 483.13(c) SS=D DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of				B. WIIN		ADDRESS CITY STATE ZIP CODE	<u> </u>	
NORTH WOODS VILLAGE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F0226 SS=D DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of KOKOMO, IN 46901 PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) PREFIX FROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE COMPLETED TAG PREFIX TAG PREFIX FROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE COMPLETED TAG PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE COMPLETED COMPLETED TO THE APPROPRIATE DATE TAG PREFIX TAG PROVIDERS PLAN OF CORRECTION TO THE APPROPRIATE DATE TAG PREFIX TAG PREFIX TAG PREFIX TAG PROVIDERS PLAN OF CORRECTION TO THE APPROPRIATE TAG PREFIX TAG PREFIX TAG PREFIX TAG PREFIX TAG PROVIDERS PLAN OF CORRECTION TO THE APPROPRIATE TAG PREFIX TAG PREFIX TAG PREFIX TAG PREFIX TAG PREFIX TAG PROVIDERS PLAN OF CORRECTION THE APPROPRIATE TAG PREFIX TAG PREFIX TAG PROVIDERS PLAN OF CORRECTION THE APPROPRIATE TAG PREFIX	NAME OF PR	ROVIDER OR SUPPLIER	₹					
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F0226 SS=D DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of	NODTH W	VOODS VII I AGE						
PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F0226 SS=D DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of					KOKOK			
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F0226 SS=D DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of	` ′							(X5)
F0226 483.13(c) SS=D DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of		`				CROSS-REFERENCED TO THE APPROPRIAT	TE	COMPLETION
SS=D DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of			LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
property.	F0226 SS=D	483.13(c) DEVELOP/IMPL ETC POLICIES The facility must written policies a mistreatment, ne residents and mi property. Based on intervice the facility failed policies and proce abuse for 1 of 5 neviewed for abuse Findings include During review of of the alleged ab a.m., indicated of Resident D report Director of Nurso on 2/20/12 that I room after reside on and moved classid "hit me right LPN #1's chin. During interview a.m., the ADON interviewed 5 res H, I, and J, who where the incides safety and abuse the ADON indicated	MENT ABUSE/NEGLECT, I develop and implement and procedures that prohibit reglect, and abuse of isappropriation of resident we and record review, I to correctly follow redures for investigating residents in a sample of 5 rise. (Resident D) It is If the investigation report ruse on 2/29/12 at 10:45 rn 2/20/12 at 1:00 p.m., red to the Assistant ring (ADON) at 1:00 a.m., red to the Assistant ring (ADON) at 1:00 a.m., red to the reall light resident in a pointed to I on 2/12/12 at 10:45 I indicated she residents, Residents F, G, reside in the same hall rut took place, regarding residents interview, red that LPN #2 who	F02		F226 Develop/Implement Abuse/Neglect, ETC Policies is the practice of this provider of follow all written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriate of resident property. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident D interviewed and Social Service assessment were performed who negative outcome. LPN interviewed along with 2 witnesses, incident was unsubstantiated LPN #2 given compassionate caregiver on 2-21-12 by ADNS. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. Residents in the facility have the potential to be affected by the alleged deficient practice. Other Residents in the facility were interviewed and no concerns were voiced. Nursi	use tion n ee vith I #2 II the	03/26/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LPKM11

Facility ID: 000064

If continuation sheet

Page 13 of 26

STATEMEN	IENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155139	B. WIN			03/01/	2012
		l .	D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	t			JEFFERSON ST		
	WOODS VILLAGE				/O, IN 46901		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	involved in the in	ncident did not work in			alleged abuse, investigations a		
	the area of the incident and she should				reporting appropriately including		
	have interviewed	l residents who resided in			notifying Executive Director (E	,	
	the area where L				immediately of any allegation abuse, neglect, or	UI	
	ino aroa whore E	zz, nz womou.			misappropriation of property b	v	
	On Folomore 20	2012 at 0:00 a t 41			3-23-12 by the SDC/designee		
		2012 at 9:00 a.m., the			ED is not notified		
	•	ovided a policy entitled,			appropriately disciplinary action	n	
		on, Reporting, and			will be taken up to and includir	ng	
	Infestation," with	n a review date of			termination. What		
	February 2010.	This policy indicated,			measures will be put into pla		
	"11. The inve	stigation will include:			or what systemic changes yo	ou	
		rations from others who			will make to ensure that the		
		nent information"			deficient practice does not recur · Staff will be		
	Imgiit have perti	mont information			recur · Staff will be re-educated by 3-23-12 by the	,	
					SDC/designee on Abuse polic		
	_	relates to complaint			being followed, proper reportir		
	#IN00104295				and investigations of alleged	5	
					abuse. · Investigation was		
	3.1 - 28(a)				completed and the nurse #2 v		
					given compassionate caregive		
					training on 2-21-12 by Assista	nt	
					Director of Nursing (ADNS) · Staff was educated on proper		
					reporting alleged abuse and		
					investigation 3-6-12 and by		
					3-23-12 by SDC/Designee.		
					Staff report allegations of abus	se,	
					to their immediate supervisor.		
					The Executive Director and/or		
					Director of Nursing Services is		
					notified and initiate the report	iO	
					the appropriate regulatory agencies. Including notifying I	FD	
					immediately of any allegation		
					abuse, neglect, or		
					misappropriation of property.	lf	
					ED is not notified appropriately	y	
					disciplinary action will be taker		
					to and including termination.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LPKM11

Facility ID: 000064

If continuation sheet Page 14 of 26

PRINTED: 03/26/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CC	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		155139	A. BUILDING B. WING		03/01/2012
	ROVIDER OR SUPPLIER		STREET 2 2233 W	ADDRESS, CITY, STATE, ZIP CODE / JEFFERSON ST MO, IN 46901	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	COMPLETION COMPLETION
				Residents who have an alleabuse will have a complete investigation initiated and residents throughout the fact will be interviewed to determabuse has occurred and if residents feel safe. This investigation will include interviews of staff, other residents, and family memb necessary. Physician and family will be notified of allegations of abuse as need. Employees that are implicing an allegation of abuse are removed from the schedule, ensure resident safety, until investigation is completed. Interdisciplinary team will rest the "24 Hour Report" and "Change of Condition" forms physician and family notificated Monday – Friday (excluding holidays) at clinical meeting Employees will have a criministory check upon hire. Employees will receive abus prevention training upon hire at least annually thereafter. The nursing manager on canotified of acute resident chon the weekend. DNS/ED is notified as needed. The Executive Director/Designed responsible for compliance of the Abuse Policy and Proce and the reporting of allegaticabuse. How the correctivation of the deficient practicular program will be monitored ensure the deficient practicular will not recur, i.e., what quassurance program will be	ers if d ded. ded. detde to the The view s for ation I is anges s e is with dure ons of ve I to ce ality

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LPKM11

Facility ID: 000064

If continuation sheet

Page 15 of 26

PRINTED: 03/26/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155139	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMPL 03/01/	ETED
	PROVIDER OR SUPPLIER	<u>l</u>	STREET . 2233 W	ADDRESS, CITY, STATE, ZIP CODE / JEFFERSON ST MO, IN 46901	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
				into place The CQI too "Staff Treatment of Resider will be utilized by the Interdisciplinary Team weel four weeks, monthly for thre months, and quarterly until compliance is achieved for consecutive quarters. Th DNS or designee is respons to monitor for compliance. CQI team reviews the audit monthly and action plans at developed if threshold of 1 not achieved to ensure com compliance. Compliance date: March 26, 2012	ets" kly for ee two e sible · The s re 00% is tinual	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LPKM11

Facility ID: 000064

If continuation sheet Page 16 of 26

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, pull ppic	00	COMPLETED
		155139	A. BUILDING		03/01/2012
		1 11 11	B. WING		
NAME OF F	PROVIDER OR SUPPLIE	R		T ADDRESS, CITY, STATE, ZIP CODE	
				W JEFFERSON ST	
NORTH	WOODS VILLAGE		KOKO	DMO, IN 46901	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0282 SS=D	483.20(k)(3)(ii) SERVICES BY CARE PLAN The services profacility must be in accordance with plan of care. Based on record facility failed to transferred the relaceration to a reduring at transfer the emergency residents with factorial (Resident C). Findings included 1. During the factorial manager on 2/20. Resident C was hematoma on he which required services a service of the pothyroidism, depression, renain and failure to the	QUALIFIED PERSONS/PER povided or arranged by the provided by qualified persons with each resident's written I review and interview, the ensure 2 or more staff esident to prevent a esident's lower left leg, er, resulting in a visit to doom where sutures were ed laceration for 1 of 3 alls in a sample of 5 ed: decility tour with the Unit 19/12 at 8:30 A.M., identified was having a er leg that had opened sutures. mical record was reviewed 50 A.M. gnoses included, but were pronic encephalopathy, anemia, bipolar, anemia, bipola	F0282	F282 Services by Qualified Persons Per Care Plan It is the practice of this provide ensure services are provided arranged by the facility by qualified persons in accordance with the written plan of care. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident C's MDS, Care Plan and resident need sheet audited to ensure appropriate transfer information was corrected. Resident C is now bein transferred with assist of 2. Certified Nursing Assist (C.N.A) was immediately give verbal counseling on proper transfers and the use of the resident need sheet on 2-18-2 by the nurse manager. How will you identify other residents having the potentiate be affected by the same alleged deficient practice and what corrective action will be	03/26/2012 er to or ce II n ee was ect. g eant n 2012 al
	Resident C's Ad	mission MDS (minimum		taken	

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) M		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIT	LDING	00	COMPLETED
		155139	B. WIN			03/01/2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIEF	8			JEFFERSON ST	
NORTH \	WOODS VILLAGE				10, IN 46901	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA'	TE COMPLETION DATE
TAG		,	+	TAU	BELIEBRET	DATE
	· · · · · · · · · · · · · · · · · · ·	nent completed on			· All Resident's MDS, Ca	re
	2/18/12 indicated Resident C's cognitive status was assessed with a BIMS (brief				Plan and resident need sheets	
					were audited to ensure	
	interview for me	ental status) with a score			appropriate transfer informatio	n
	of 4/15, which indicated the resident had				was correct.	
	severe cognitive impairment. Her				Nursing staff will be	
	functional status was assessed as extensive assistance of two+ persons for transfers from the wheelchair to the bed. She was assessed as not steady with				re-educated on following MDS	
					Care Plan and need sheets for resident transfers by the SDC	
					designee by 3-23-2012.	Si
					accigned by 0 20 20 12.	
		d as not steady with			What measures will be put in	ito
	transfers.				place or what systemic	
					changes you will make to	
	_	l therapy notes dated			ensure that the alleged	
	2/15/12 indicated	d the resident needed			deficient practice does not	
	"Max assist x's 2	to sit to stand in bar			recur	
	(parallel type bar	rs)."			All Decident's MDS Co.	ro
					 All Resident's MDS, Call Plan and resident need sheets 	
	The physical the	rapy notes dated 2/15/12			were audited to ensure	'
		ident "needed assist x 3			appropriate transfer informatio	n
		c (wheelchair) behind			was correct.	
	her."	(wheelenan) bening			 Nursing staff will be 	
	nci.				re-educated on following MDS	
	Th. C. D. 1	-4-10/11/10 C 4			Care Plan and need sheets for	
		ated 2/11/12 for the			resident transfers by the SDC designee by 3-23-2012.	OI
	^	risk related to: recieves			Nursing Management st	taff
	(sic) cardiac and				will make rounds daily on all sl	
	medications, nee	eds extensive assist for			to ensure residents are	
	transfer and toile	eting." The approaches			transferred per care plan.	.
	included but wer	re not limited to, "			· Upon admission and du	
	Provide assistance	ce as needed"			the Care Plan review process, Care Plans, MDS and need	
					sheets will be reviewed to ens	ure
	The progress not	tes dated 2/18/12 at 7:17			appropriateness for each	
		'Writer was called into			resident.	
	1	om by son stating "my				
	` ′				How the corrective action(s)	
	mom is bleeding	, please come help us."			will be monitored to ensure t	he

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPLETED	
		155139	B. WIN			03/01/2012	
e e e				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	· ·		2233 W	JEFFERSON ST		
	WOODS VILLAGE				1O, IN 46901		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY))N
TAG		R LSC IDENTIFYING INFORMATION)		TAG	· ·	DATE	
	` ′	into room to find a huge			deficient practice will not recur? i.e., what quality		
	"L" shaped jagged edge of her LLE (left lower extremity) cut open and bleeding.				assurance program will be p	ıt .	
					into place		
	approx (sic) area	a to be measured 33 cm					
	(centimeters). resident (sic) had approx				· The CQI tool "C.N.A		
	+2 pitting edema	a on BLE. area (sic)			Resident Care" will be comple		
	cleaned with wa	ter. areas (sic) was			weekly for four weeks, monthly for three months, and then	′	
	seaping (sic) wit	th blood. no (sic) c/o			quarterly until compliance is		
	(complaints of) SOB (short of breath) noted. resident (sic) has mild c/o pain at L leg. aid (sic) was helping get resident to bed with a nice gentle transfer, and noticed bleeding. area (sic) around wound				maintained for two consecutive	e	
					quarters.		
					The CQI Team will revie		
					the data. If the threshold of 10		
					for compliance is not met then action plan will be developed.	an	
	_	ing noted. family (sic) in			dollon plan will be developed.		
	room"	ing notes. ranning (sie) in					
	100111				Compliance date: March 26, 2012		
		transferred to the					
		m on 2/18/12 at 8:03					
	P.M. The emerg	gency room notes					
	indicated the res	ident was a "high fall					
	risk," had deme	ntia, swelling to her left					
	lower leg, and ha	ad a laceration to the left					
	lower leg that wa	as a jagged and measured					
	9 centimeters. T	The emergency room					
	physician suture	d the laceration closed.					
	During an interv	riew with the ADON					ļ
	_	tor of Nurses) on 2/29/12					
	`	e indicated the DON had					
	•						
		tear had occurred during					
		sfer. During a follow-up					
		ne ADON on 2/29/12 at					
		ndicated the supervisor in					
	the building that	night had talked with the					

PRINTED: 03/26/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION 00	(X3) DATE : COMPL	
11112 12111	or condition,	155139		LDING		03/01/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				JEFFERSON ST		
NORTH \	WOODS VILLAGE			KOKON	1O, IN 46901		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		er she needed to have		TAG	DEFICIENC!)		DATE
		nother CNA helping her					
	to transfer the re-						
	to transfer the re-	sident.					
	Review of an un	dated written statement					
	made by CNA #4	4, provided by the DON					
	on 3/1/12 at 8:30	A.M., indicated "I was					
	educated after in	cident occurred c (with)					
	hematoma to res	idents (L) (left) lower leg					
to always have two people during							
	transfers @ all ti	mes."					
	Review of the ur	ndated Resident Care					
		on 2/29/12 at 1:45 P.M.,					
	_	nt C was dependent for					
		eded the assistance of 2					
		transfer her. This form					
		and geri-sleeves were to					
		resident to help prevent					
	skin tears.						
		dated guideline provided					
		1 3/1/12 at 12:49 P.M.,					
		indicated "Implement					
		reduce hazard(s) and g adequate supervision					
	l ' '	timely intervention by					
	· ·	ts staff to prevent or					
	reduce likelihood	•					
		he resident's needs, goals,					
		recognized standards of					
	practice"	<i>C</i>					
	This Federal tag	relates to complaint #					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LPKM11

Facility ID: 000064

If continuation sheet

Page 20 of 26

PRINTED: 03/26/2012 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155139	A. BUILDING B. WING	00	COMPLETED 03/01/2012			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2233 W JEFFERSON ST KOKOMO, IN 46901					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE			
	IN00104351. 3.1-45(a)(2)							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LPKM11

Facility ID: 000064

If continuation sheet Page 21 of 26

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155139 NAME OF PROVIDER OR SUPPLIER NORTH WOODS VILLAGE		A. BUILDING 00 CC			(X3) DATE COMPL 03/01/	ETED	
(X4) ID PREFIX TAG F0323 SS=G	SUMMARY S (EACH DEFICIEN REGULATORY OR 483.25(h) FREE OF ACCII HAZARDS/SUP The facility must environment rem hazards as is poreceives adequa	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) DENT ERVISION/DEVICES ensure that the resident nains as free of accident ssible; and each resident te supervision and es to prevent accidents.		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Based on record facility failed to transferred the relaceration to a reduring at transfer the emergency replaced in a jagger residents with fa (Resident C). Findings include 1. During the farm Manager on 2/29 Resident C was in hematoma on he which required some conditions of the	review and interview, the ensure 2 or more staff esident to prevent a sident's lower left leg, r, resulting in a visit to soom where sutures were d laceration for 1 of 3 lls in a sample of 5 d: d: cility tour with the Unit 1/12 at 8:30 A.M., dentified was having a r leg that had opened utures. ical record was reviewed 1/10 A.M. gnoses included, but were ronic encephalopathy, anemia, bipolar, failure, malnutrition,	F03	23	F323 Free of Accident Hazards/Surpervision/Device It is the practice of this provide ensure that the resident environment remains as free of accident hazards as is possible. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident C's MDS, Car Plan and resident need sheet audited to ensure appropriate transfer information was correct. Resident C is now being transferred with assist of 2. Certified Nursing Assist (C.N.A) was immediately give verbal counseling on proper transfers and the use of the resident need sheet on 2-18-2 by the nurse manager.	er to of le. II n ee was ect. g tant n	03/26/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LPKM11

Facility ID: 000064

If continuation sheet

Page 22 of 26

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155139		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 03/01/2012	
	PROVIDER OR SUPPLIER		STREET . 2233 W	ADDRESS, CITY, STATE, ZIP CODE / JEFFERSON ST MO, IN 46901	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION
	data set) assessm 2/18/12 indicated status was assess interview for me of 4/15, which in	nission MDS (minimum lent completed on a la Resident C's cognitive led with a BIMS (brief lental status) with a score ladicated the resident had limpairment. Her was assessed as		How will you identify othe residents having the poter to be affected by the same alleged deficient practice what corrective action will taken	ntial e and
	transfers from th She was assessed transfers.	nce of two+ persons for e wheelchair to the bed. I as not steady with		All Resident's MDS, Plan and resident need she were audited to ensure appropriate transfer informations was correct.	eets
	2/15/12 indicated "Max assist x's 2 (parallel type bar	,		Nursing staff will be re-educated on following M Care Plan and need sheets resident transfers by the SE designee by 3-23-2012.	for
	indicated the rest to sit down in woher." The Care Plan da	rapy notes dated 2/15/12 ident "needed assist x 3 ic (wheelchair) behind ited 2/11/12 for the		What measures will be put place or what systemic changes you will make to ensure that the alleged	
	(sic) cardiac and medications, nee transfer and toile	risk related to: recieves psychotropic ds extensive assist for ting." The approaches e not limited to, "		deficient practice does no recur All Resident's MDS,	Care
	P.M., indicated "	es dated 2/18/12 at 7:17 Writer was called into om by son stating "my		Plan and resident need she were audited to ensure appropriate transfer informations was correct. Nursing staff will be	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
		155139	B. WIN			03/01/	2012
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	· ·		2233 W	JEFFERSON ST		
	WOODS VILLAGE			KOKON	//O, IN 46901		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION
TAG	<u> </u>	R LSC IDENTIFYING INFORMATION)		TAG	·		DATE
	_	g, please come help us."			re-educated on following MDS Care Plan and need sheets fo		
	writer (sic) went into room to find a huge			resident transfers by the SDC or			
	"L" shaped jagged edge of her LLE (left				designee by 3-23-2012.		
	lower extremity) cut open and bleeding.						
	approx (sic) area	to be measured 33 cm			Nurse Management staff		
	(centimeters). resident (sic) had approx +2 pitting edema on BLE. area (sic)				will make rounds daily on all s	nitts	
					to ensure all residents are transferred per care plan.		
	cleaned with wa	ter. areas (sic) was			transferred per sare plan.		
	seaping (sic) wit	th blood. no (sic) c/o			· Upon admission and du	ring	
	(complaints of) SOB (short of breath) noted. resident (sic) has mild c/o pain at L leg. aid (sic) was helping get resident to				the Care Plan review process,		
					Care Plans, MDS and need		
					sheets will be reviewed to ens appropriateness for each	ure	
					resident.		
	bed with a nice gentle transfer, and noticed bleeding. area (sic) around wound						
	_	ing noted. family (sic) in					
		ing noted. Tanniy (sic) in					
	room"				How the corrective action(s)		
					will be monitored to ensure t	ne	
		transferred to the			deficient practice will not recur? i.e., what quality		
		m on 2/18/12 at 8:03			assurance program will be p	ut	
	_	gency room notes			into place		
		ident was a "high fall			-		
		ntia, swelling to her left					
	lower leg, and ha	ad a laceration to the left			The COLLEGE "C. N. A.		
	lower leg that wa	as a jagged and measured			The CQI tool "C.N.A Resident Care" will be comple	ted	
	9 centimeters. T	The emergency room			weekly for four weeks, monthly		
	physician suture	d the laceration closed.			for three months, and then	,	
					quarterly until compliance is		
	Review of the er	nergency room report			maintained for two consecutive	Э	
		at 8:05 P.M., indicated			quarters.		
		a 9 centimeter laceration			The CQI Team will revie	÷W	
		leg with a small amount			the data. If the threshold of 10		
		d. The left leg laceration			for compliance is not met then		
	_	the physician and steri			action plan will be developed.		
	•	1 2					
	strips were appli	ed with an ACE bandage					

PRINTED: 03/26/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUC		00	(X3) DATE SURVEY COMPLETED		
III.D I EARL OF CORRECTION		155139	A. BUILDING B. WING		03/01/			
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER				2233 W JEFFERSON ST				
NORTH WOODS VILLAGE			KOKOMO, IN 46901					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE!		DATE	
	applied to the left lower leg. Resident C was discharged back to the facility.							
	was discharged t	ack to the facility.			Compliance date: March 26, 2012			
	The progress notes dated 2/18/12 at 9:25				Compliance date. March 26, 2012			
		res returned from ER via						
	(name of ambulance service) has a running suture to LLE skin tear with steri strips and ace wrap"							
	_	iew with the ADON						
	(Assistant Director of Nurses) on 2/29/12							
	at 1:40 P.M., she indicated the DON had							
	told her the skin tear had occurred during							
		fer. During a follow-up						
		e ADON on 2/29/12 at						
		dicated the supervisor in						
		night had talked with the r she needed to have						
	assistance with another CNA helping her to transfer the resident.							
	to transfer the re-	ident.						
	Review of an und	dated written statement						
	made by CNA #4	4, provided by the DON						
	•	A.M., indicated "I was						
	educated after in	cident occurred c (with)						
	hematoma to resi	idents (L) (left) lower leg						
	to always have to	wo people during						
	transfers @ all ti	mes."						
		1 . 10 . 11 6						
		idated Resident Care						
	_	n 2/29/12 at 1:45 P.M.,						
		nt C was dependent for						
		ded the assistance of 2 transfer her. This form						
	starr members to	uansiei nei. Tins ioini						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LPKM11

Facility ID: 000064

If continuation sheet

Page 25 of 26

PRINTED: 03/26/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155139	A. BUILDING B. WING	00	COMPLETED 03/01/2012			
NAME OF PROVIDER OR SUPPLIER NORTH WOODS VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2233 W JEFFERSON ST KOKOMO, IN 46901					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
		and geri-sleeves were to resident to help prevent						
	by the ADON or for "Accidents" i interventions to r risk(s), including (observation and the facility and it reduce likelihood consistent with the plan of care, and practice"	dated guideline provided a 3/1/12 at 12:49 P.M., ndicated "Implement reduce hazard(s) and gadequate supervision timely intervention by as staff to prevent or d of a accident), he resident's needs, goals, recognized standards of relates to complaint #						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LPKM11

Facility ID: 000064

If continuation sheet Page 26 of 26